JACK REED
RHODE ISLAND

COMMITTEES

ARMED SERVICES
BANKING
HEALTH AND EDUCATION
JOINT ECONOMIC COMMITTEE

United States Senate

WASHINGTON, DC 20510–3903

PLEASE RESPOND TO:

WASHINGTON, DC:
320 HART SENATE OFFICE BUILDING
WASHINGTON, DC 20510–3903
(202) 224–4642

RHODE ISLAND:
201 HILLSIDE ROAD
SUITE 200
GARDEN CITY
CRANSTON, RI 02920–5602
(401) 943–3100

TDD RELAY RHODE ISLAND
1–(800) 745–5555

http://reed.senate.gov

May 16, 2001

The Honorable Tommy Thompson
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington DC, 20201

Dear Secretary Thompson:

As you know, recently published evidence indicates that children who are exposed to lead at levels now considered safe may still experience developmental disabilities and irreversible neural damage. In light of this new information, we are writing to ask you to use the full extent of your administrative authority to ensure that the children at risk – primarily those in low-income families – are adequately protected from lead hazards, screened for toxic exposures, and treated for lead poisoning.

Despite considerable progress in controlling lead exposure in the United States, nine percent of American children have elevated blood lead levels [levels of at least 10 micrograms per decileter (µg/dL)], and new evidence indicates that as many as one in 30 children nationwide may suffer harmful effects from lead exposure. The General Accounting Office (GAO) estimated that three-fourths of all children ages one through five with elevated blood lead levels are enrolled in Medicaid and other federal health care programs – nearly 700,000 children nationwide. Although Federal regulations require that all children in Medicaid under the age of two must be screened for lead poisoning, studies indicate that 80 percent of these children are not being tested and that many states have not adopted Medicaid's mandatory lead screening policy. GAO estimates that 65 percent of the lead poisoned children enrolled in Medicaid – approximately 352,000 – are never treated.

Mr. Secretary, we know you agree that this is unacceptable. To this end, we are writing to request that the Administration take the following steps to address this problem:

1. **CDC should initiate a review of the current blood lead level standard of 10 µg/dL to determine whether the national standard needs to be lowered.** A recent study published by researchers at the Children's Hospital Medical Center in Cincinnati indicates that children exposed to lead at levels now considered safe scored substantially lower on intelligence tests and may suffer other adverse effects, such as hearing loss, speech delay, balance difficulties, and violent tendencies. CDC, through the HHS Advisory Committee on Childhood Lead Poisoning Prevention, should work with public health experts to determine whether the federal standard for acceptable blood lead levels should be lowered.

2. **HHS should use its administrative authority and provide Medicaid reimbursement for the laboratory tests necessary to determine the source of a child's lead poisoning in limited situations.** For blood lead screening to be a meaningful prevention service, identification of a child with an elevated blood lead level must trigger services that will lower the child's blood lead level. The responsibility for lead poisoning screening, treatment, and lead hazard control is shared by many agencies, including CDC, HCFA, and HUD. We believe that screening services – identifying children with lead poisoning and working together with other agencies to identify the source of the lead hazard – are legitimate responsibilities of the Medicaid program.

   Under 1905(a)(27), the Secretary of Health and Human Services has the administrative flexibility to provide Medicaid reimbursement for environmental laboratory analysis to determine the presence of lead. For children who have been diagnosed with elevated blood lead levels, Medicaid should reimburse for a one-time environmental laboratory analysis of paint, dust, and/or water samples from the child's primary residence for lead content. Medicaid would not reimburse for environmental laboratory analyses conducted in schools, day care centers, or other non-residential facilities. In addition, Medicaid would not have to reimburse for environmental laboratory analyses conducted for children who do not have elevated blood lead levels. Expanding Medicaid coverage for this type of laboratory service in this limited situation (as recommended by the HHS Advisory Committee on Childhood Lead Poisoning Prevention) ensures that the program assumes its full responsibility in lead poisoning screening while protecting against potential abuses and incurring minimal costs.

3. **HHS should update Congress on the Department's effort to increase the number of Medicaid enrolled children who are screened for lead poisoning.** In April of 2000, HCFA, CDC, ACF, and HRSA launched a joint effort to increase the number of children enrolled in Medicaid screened for lead poisoning. We are hoping you can advise us on progress the Department has made over the past year? Has HCFA increased its success in ensuring that states comply with the federal requirement that all children in Medicaid under the age of two must be screened for lead poisoning? An update on these issues would be useful to assure that we are able to work together to address the problem of lead poisoning in low-income children.

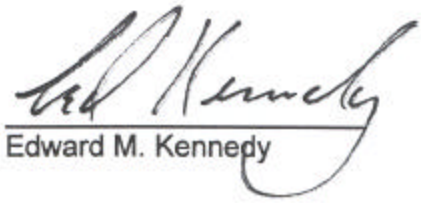
Thank you for your time and attention to this extremely important issue. We look forward to working with the Department to ensure that children at risk of lead poisoning, as well as those diagnosed with the disease, receive the full complement of services and treatment necessary to lead healthy and productive lives.

Sincerely,

Jack Reed
United States Senator

Robert G. Torricelli
United States Senator

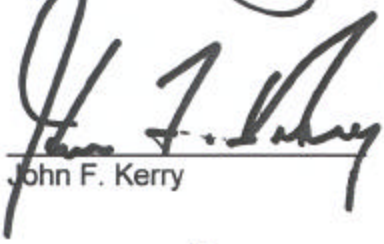
Hillary Rodham Clinton



Edward M. Kennedy

Jon S. Corzine

Richard J. Durbin



John F. Kerry

Dianne Feinstein

Jean Carnahan

Jeff Bingaman